

45 Neshoba County General Hospital  
**EMERGENCY PHYSICIAN RECORD**  
 ♦ Altered Mental Status ♦

LUKE, CHRISTOPHER C  
 NANNEY, JAMES 05/30/2013  
 M 34 Y [REDACTED]  
 6  
 10408266 MER

TRIAGE TIME: 1035  
 TIME IN ROOM: 1035 ROOM#: ED2  
 HISTORIAN: patient spouse paramedics NH records  
 AGE 34 M F RACE W  
 HX / EXAM LIMITED BY: Butler sign EMS Arrival  
 TRANSFER FROM: see transfer record

**HPI**

chief complaint: decreased mental status / confusion  
 low blood sugar / diabetic fever  
 onset / duration: severe w/ lethargic  
2 min / hrs / days ago gradual-onset  
 upon waking cannot confirm onset gone now intermittent  
 better continues in ED more than 3 hours constant

**character of altered mental status:**

disoriented / confused / combative / agitated / trouble concentrating  
 unresponsive / seizure activity / decreased responsiveness

In jail for past 3 days -  
Altercation on 5.28.13  
3 ANOTHER ERROR/AR

**context:**

nursing home resident / chronic dementia / depression  
 found unresponsive / unknown duration 2 days  
 by nursing home staff bystander family:  
 dextrostick PTA ( ) given D50 / Narcan PTA  
 good / marginal / no response  
 recent / heavy alcohol intake (beer / wine / liquor)  
 last drink:  
 drug abuse / overdose  
 trauma head injury possible  
 infection / other family members sick  
 new medications

**Usually:**

**Cognition**

alert, oriented x3  
 alert but confused  
 alert but disoriented to time  
 poor alertness

**Gait**

walks w/o assistance  
 unable to walk  
 uses a cane / walker  
 walks only w/ assistance

**associated symptoms:**

recent illness / fever  
 recent injury  
 chest pain  
 neck / back pain  
 trouble breathing  
 abdominal pain  
 nausea / vomiting  
 new weakness  
 decreased ability to stand / walk  
 weak difficult off balance  
 cannot walk cannot stand falling  
 fainting / dizziness  
 involuntary movements / seizure  
 headache

Similar symptoms previously

Recently seen / treated by doctor / hospitalized

**ROS**

EYES problems with vision GI  
 ENT black stools MS  
 sore throat joint pain  
 trouble swallowing SKIN  
 CVS rash  
 palpitations LYMPH  
 RESP swollen glands  
 cough ankle swelling  
 GU problems urinating PSYCH  
 LNMP preg post-menop anxiety / depression  
 except as marked positive, all systems above reviewed and found negative

\*CONST / CVS / RESP / NEURO components also addressed in HPI

**PAST HX** no chronic diseases

cardiac disease Afib CAD CHF MI asthma / COPD  
 diabetes Type 1 Type 2 hepatitis / HIV  
 diet / oral / insulin hyperlipidemia  
 hypertension insect bite  
 confusion / dementia GI bleeding  
 CVA / TIA deficit  
 head trauma  
 overdose  
 seizure disorder  
 psychiatric disorder  
 schizop. / bipolar / depression  
 old records reviewed / summary:

Drug Abuse  
Childhood Seizures  
 Surgeries / Procedures none

appendectomy hysterectomy / BTL  
 cardiac bypass / stent pacemaker  
 cholecystectomy tonsillectomy

Hernia repair

Immunizations: influenza / pneumovax UTD / referred to PCP

Medications none see nurses note  
 aspirin coumadin clopidogrel

Allergies NKDA  
 see nurses note

**SOCIAL HX**

smoker past ppd / past / quit days / mos / yrs ago  
 drugs past alcohol (recent / heavy / occasional)

**FAMILY HX**

CVA CAD HTN cerebral aneurysm

Ann Richardson RN  
 HISTORY- Nurse sign after recording ROS, PFSH; Physician initial after reviewing with patient and confirming or revising

Circle positives, backlash negatives, check V normals

Luke 0197



**HISTORY AND PHYSICAL EXAMINATION**

**ANDERSON REGIONAL MEDICAL CENTER  
MERIDIAN, MS 39301**

Patient Name:	LUKE, CHRISTOPHER C	Location:	IC
Patient DOB:	██████/78	Room #:	0116
Attending Physician:	Malloy, David MD	Acct #:	J19398528
Admission Date:	05/30/13	Unit #:	M00632356

DATE: 05/30/2013

**REASON FOR ADMISSION:** HEAD TRAUMA

**HISTORY:** 34 year old male seen initially at Neshoba General Hospital Emergency Room this morning with history of headaches. The patient was apparently incarcerated in Philadelphia since 05/24/13 for "possession of meth". According to family members he was "okay" at the time of his arrest but they have not seen him for a couple of days until today. The patient cannot recall any trauma to the head but he is somewhat vague about his history. He complains of headache with nausea and photophobia. He has no complaints of weakness or numbness. The family notes that he has been "sleepy".

**REVIEW OF SYSTEMS:** No chest pain or shortness of breath. No abdominal discomfort.

**PAST MEDICAL HISTORY:** Negative for heart disease, hypertension or diabetes.

**SOCIAL HISTORY:** Denies alcohol intake and he is a nonsmoker. He and his wife do use methamphetamine (the patient both smokes and injects it) and they have been doing so for at least a year.

**MEDICATIONS:** No long-term meds.

**ALLERGIES:** None.

**PHYSICAL EXAMINATION**

**VITAL SIGNS:** Blood pressure 110/70, heart rate is 60 per minute. Oxygen saturation 98%. He is afebrile.

**CHEST EXAMINATION:** Reveals good air entry equal bilaterally with no adventitious noises.

**HEART:** Sounds are normal with no bruits in the carotids.

**ABDOMEN:** Soft and nontender with normal guarding or rigidity. Bowel sounds are present.

**EXTREMITIES:** Reveal no obvious deformities.

There is an old bruise on the dorsal thoracic area in a right paramedian location. There is a small abrasion in the right upper quadrant of the abdomen. There is some bruising in the right ear lobe and the skin just behind the right ear.

From a Neurologic prospective he is drowsy but he easily arousable. He keeps his eyes closed but does open them to voice. Pupils react equally. Extraocular movements are full. Tongue protrudes in the midline. Facial sensation is within normal limits. Tympanic membranes are normal. He is oriented to place and person but not to time. He moves all four limbs well with equal strength. Normal grip to the outstretched upper extremities is noted. Sensory examination is normal to light touch bilaterally in the upper and lower extremities. Plantar responses downgoing.

## HISTORY AND PHYSICAL EXAMINATION

ANDERSON REGIONAL MEDICAL CENTER  
MERIDIAN, MS 39301

Patient Name:	LUKE, CHRISTOPHER C	Location:	IC
Patient DOB:	78	Room #:	0116
Attending Physician:	Malloy, David MD	Acct #:	J19398528
Admission Date:	05/30/13	Unit #:	M00632356

Investigations include CT scan of the brain (performed at Neshoba General Hospital). This reveals right frontal and right temporal contusions with some surrounding low density compatible with edema. There is no shift of the midline structures. Ventricles and cisterns are normal. CT scan of the cervical spine was performed at Anderson Hospital is normal. Chest x-ray is unremarkable.

Lab data reveals negative urine drug screen. He has mildly elevated white count of 15,000. Hemoglobin and hematocrit are normal. Platelet count is normal. Slightly elevated INR at 1.16 is noted. Electrolytes are within normal limits. Slight elevation of SGOT is noted and the remainder of his liver function appears within normal limits.

**IMPRESSION:** TRAUMATIC RIGHT FRONTAL AND TEMPORAL CONTUSION.

**RECOMMENDATIONS:** The patient is being admitted to the hospital for observation. No immediate need for surgical intervention. Observe for changes in mental status, seizures, development of focal signs.

**ADDENDUM:** The patient does have a past medical history of "seizures" many, many years ago. He took Phenobarbital for a while but is not on any medications at this time.

Malloy, David MD

MALDA /VM

DICT: 05/30/13      TIME: 1720  
 TRANS: 05/31/13      TIME: 1259

## HISTORY AND PHYSICAL UPDATE: (If done prior to date of admission)

- ☐ H&P was reviewed, the patient was examined and there are no changes in the patient's condition since the H&P was completed.
- ☐ H&P was reviewed, the patient's condition revealed the following changes:
- ☐ Addition(s) to current H&P due to missing element(s), if applicable: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name:	LUKE, CHRISTOPHER C	Room#:	0116	Acct#:	J19398528
Attending Physician:	Malloy, David MD			Unit#:	M00632356
Dictating Physician:	Malloy, David MD				

## DISCHARGE SUMMARY

ANDERSON REGIONAL MEDICAL CENTER  
MERIDIAN, MISSISSIPPI 39301

Patient Name:	LUKE, CHRISTOPHER C	Acct#:	J19398528
Patient DOB:	██████/78	Unit#:	M00632356
Attending Doctor:	Malloy, David MD	Discharge Date:	06/03/13
Admission Date:	05/30/13		

ADMITTED: 05/30/2013  
DISCHARGED: 06/03/2013

DISCHARGE DIAGNOSIS: RIGHT FRONTAL TEMPORAL CONTUSION

OPERATIVE PROCEDURE: NONE

This is a 34 year old right-handed white male who was initially evaluated at Neshoba General Hospital for complaints of headache. He had been incarcerated in the local jail since 05/24/13 for possession of methamphetamine. There appears to have been some sort of traumatic event during the course of his incarceration. He was taken to his local hospital because of progressively increasing headache and drowsiness. He was found to have right frontal temporal contusions. He was transferred to Anderson Hospital for further evaluation.

His examination was nonfocal with respect to motor and sensory function. He was quite drowsy but arousable to voice. He did have right frontal and temporal contusions on CT scan. There was some edema surrounding the contusions. He was admitted to the hospital for observation. His neurologic status and vital signs remained relatively stable during the course of his hospital stay. Level of consciousness gradually improved to the point where at discharge he was awake, oriented and speaking appropriately without focal neurologic deficit. He did have some swelling and redness to both the right elbow region with a small pustule. He was placed on some Keflex empirically for this. At discharge he was given a prescription for Keflex 500 mg q.i.d. He was advised to use Tylenol for headache. He was not given any narcotic prescriptions. He was cautioned to return to the Emergency Room if he has any increasing headache or develops any focal neurologic signs. He will be seen in my clinic in two weeks time with a follow up CT scan of the brain. He was advised to avoid the use of illegal medications. He was advised to avoid any heavy strenuous physical activity.

CONDITION AT DISCHARGE: Stable.

Malloy, David MD

MALDA/VM

DICT: 06/03/13 TIME: 0832  
TRANS: 06/06/13 TIME: 1256  
ESIGN:

Patient Name:	LUKE, CHRISTOPHER C	Acct#:	J19398528
Attending Doctor:	Malloy, David MD	Unit#:	M00632356
Dictating Doctor:	Malloy, David MD		
Discharge Date:	06/03/13	Location:	3E



# Ear, Nose & Throat Surgical Group

*An affiliate of St. Dominic Medical Associates*

August 5, 2013

RE: Christopher Luke  
DOB: [REDACTED]/78

*Bryan M. Clay, MD  
Beverly C. Fulcher, MD  
James D. Gordon, MD  
Kyle F. Gordon, MD  
Jess C. Roberts, MD  
Mickey P. Wallace, MD*

To Whom It May Concern:

Mr. Luke has been seen in the office on two occasions and brought by both his parents. His first visit was on 7/17/13 and subsequent visit was on 8/01/13. On his initial visit, the history was primarily given by the parents. On the subsequent visit, they are here as well and they have brought paperwork with medical records from his most recent medical facilities, which are Neshoba County General Hospital and Jeff Anderson Hospital in Meridian. Based on the information by the patient and his parents and these medical records, it appears that the patient was a jail inhabitant in Neshoba County at the onset of his medical situation. Apparently, there was an altercation within the jail and he was subsequently found to be somnolent and initially taken to the Neshoba County Hospital. He was found to have some degree of intracranial trauma, with a right frontal and temporal contusion and transferred to Jeff Anderson Hospital where he was seen by the neurosurgery people there, Dr. David Malloy, and managed for several days.

His physical injuries noted were that he had a bruising around the right earlobe and behind the right ear consistent with Battle's signs. A CT scan did indicate right frontal and right temporal contusions, and he is also noted to have a left temporal bone fracture. The patient states at that time that he was under medical care, he noted that his hearing was completely nonfunctional in either ear. He could hear nothing in the left ear, but gradually over a period of a week or so began to get some hearing back in the right ear.

He has had two audiograms, or hearing tests, done at our facility and both tympanograms were normal, consistent with intact tympanic membranes. He has a consistent sensorineural or nerve hearing loss. The left ear is completely non-functional, which would be consistent with a temporal bone fracture. The right ear shows a significant bell-shaped curve with sensorineural hearing loss at the low frequencies and very severe in the high frequencies, with the best hearing at 1000Hz in the discrimination level of 80%.

To summarize, it appears that this patient has significant cerebral trauma with a left temporal bone fracture and right temporal bone trauma with subsequent complete loss of hearing in the left ear, which is not recoverable. He has some functional hearing in the right ear and this all does appear to be of an acute onset secondary to the recent trauma.

I hope this information is helpful and feel free to contact this office if further information is needed.

Best regards,

Mickey P. Wallace, M.D.

Luke 0224

MPW:amts/1 8.06